Adult Guardianship Program Referral Requirements

**Pension Management Contract (PMC)**

- Client Profile – 3 pages
- Pension Management Contracts – 3 pages (Client signs 3 sets)
- Service Canada “Consent to Communicate Information to an Authorized Person “ (for OAS & CPP) - 1 page (Client signs 2 sets)
- Canada Revenue Agency “Authorizing or Cancelling a Representative – 2 pages (Client signs the 2nd page at the bottom)
- Letter to Canada Revenue Agency re: Stop direct deposit - 1 page (Client signs)
- Release of Information form and letter - 2 pages (1 form and 1 letter, client signs one sets per service provider / bill)
- MSD Consent to Disclosure of information - 1 page (Client Signs)

Please note: client needs to sign additional Pension Management Contract (one per income) for pension/income other than OAS, CPP and MSD assistance.

Please mail all original signed forms to The Bloom Group Adult Guardianship Program for file opening.

315B Powell Street,
Vancouver, BC.
V6A 1G5
CLIENT PROFILE

Type of Authority

- [ ] Pension Management Contract
- [ ] Pension Trustee
- [ ] Discretionary Trust

DOB: __/__/____ (Month / Day / Year)
Place of Birth: ________________________________ (City / Province / Country)

SIN: __________________________ Gender: [ ] Male [ ] Female [ ] Other

Living Status: Common-law / Single / Widowed / Divorced / Married

RESIDENCE

Current address: ____________________________________________ Phone: _____________

Current Per Diem / Rental Rate: _____________________________
Facility/Landlord Name: ____________________________________ Phone: _____________

Is address change necessary? Yes / No
Will client be moving? Yes / No

If Yes please outline moving arrangements: _____________________________

FAMILY AND FRIENDS (Contact information)

Name: ___________________________ Name: ___________________________
Relationship: ___________________ Relationship: _____________________
Address: ________________________ Address: _______________________

Phone: _________________________ Phone: _______________________

REFERAL INFORMATION

Referring Agency: __________________________
Name of person referring or contact: __________________ Title: ______________________
Agency Address: __________________________
Phone: __________________ Fax: __________________
Email: __________________________
REASON FOR REFERRAL

MEDICAL INFORMATION PHN ______________________________
Doctor’s Name ______________________________ Phone ______________________________

GOALS AND EXPECTATIONS/ (upcoming purchases): __________________________________________

OTHER SUPPORT AGENCY Organization ______________________________
Contact Name ______________________________ Title ______________________________
Address ______________________________ Phone ______________________________ Fax:

FINANCIAL INFORMATION - INCOME
OAS $ __________________ CPP$ __________________ GIS $ __________________
DVA $ __________________ R/K #: __________________ Sen. Supp. __________________
Gain / Other $ __________________

Do you have any instructions regarding the income?

__________________________________________________________

INCOME TAX Filed taxes current year: ____________ Last Year Income Tax filed ____________

Do you want to store financial documents in TBGCSS fire-safe vault? Yes / No

Do you want your money transferred from your bank account to AGP for easy access. Yes / No

Should you wish to transfer any money you’re your account, you would need to arrange it.

BILL PAYMENTS

Charge accounts
Company ____________________________ Card# __________________ Amount owed $______
Instructions: ________________________________________________________________

__________________________________________________________
UTILITIES
Hydro account #____________________

Cable account #____________________ Service provider____________________

Phone account #____________________ Service provider____________________

Other ________________________________

DISABILITY TAX CREDIT
Would you qualify for a Disability Tax Credit? This refers to people who have disabilities where normal functions are impaired or movement and abilities are severely restricted.

Do you want the AGP to send a DTC application?  Yes ______  No ______

BUDGET PLAN


WILL:

Do you have a Will?  Yes / No  Is your Will current? Yes / No

If Yes, please state the location of the Will:

Name & location of Executor/ix:

Phone: ________________________________

If Will is outdated, do you want a codicil to your Will?  Yes / No
If you have no Will, do you want a Will?  Yes / No
Would you like a referral to a notary public to acquire a Will?  Yes / No
Do you want a copy of your Will stored in TBGCSS fire-safe vault?  Yes / No

FUNERAL ARRANGEMENTS

Do you have pre-arrangements made:  Yes / No

If Yes, name of funeral home: ________________________________ Phone: ______

Do you have any instructions that you want the AGP to carry out?

OTHER RELEVANT INFORMATION
PENSION MANAGEMENT CONTRACT

I, [print name], of [print address], have asked The Bloom Group Community Services Society ("The Bloom Group") to assist me with the management of my income and expenses, which may include, without limitation, the receipt and management of my pension income from various sources (my "Pension Income") and my expenses and bills and any other services which may be required to facilitate the management of my income and expenses (the "Services").

Fees

I agree that the compensation to be paid to The Bloom Group for providing the Services will be as follows:

1. **Opening Fee**: an initial opening fee of $25.00 at the time that an account is established for me by The Bloom Group;

2. **Monthly Program Fee**: a monthly program fee of $45.00;

3. **Investment Fee**: a quarterly investment fee of 0.25% of the gross funds managed by The Bloom Group on my behalf (based on the average gross assets over the immediately preceding three month period); and

4. **Closing Fee**: a closing fee of 1.0% of the gross funds in my account with The Bloom Group at the time of the account closing;

(together, the "Fees").

Changes to Fees

I acknowledge and agree that the Fees will be reviewed by The Bloom Group annually and may be changed from time to time by The Bloom Group. The Bloom Group will use its reasonable efforts to advise me in advance of any fee changes.

Trust Funds

I acknowledge and agree that The Bloom Group will keep a separate record of any funds and assets received by and/or held by The Bloom Group on my behalf (my "Trust Fund") but for the purposes of investment and administration, The Bloom Group may hold my Trust Fund and other trust funds for The Bloom Group’s other clients in one or more combined accounts and The Bloom Group will allocate all trust receipts and disbursements among the combined trust accounts proportionately. I acknowledge and agree that I will need to report any trust income receipts that I may receive from The Bloom Group on my personal income tax return for the appropriate tax year.

Investment of Trust Funds

I acknowledge and agree that The Bloom Group will invest my Trust Fund in accordance with The Bloom Group’s Investment Policy (the “Policy”), as may be set or amended from time to time by The Bloom Group’s Board of Directors and The Bloom Group will not be liable for any loss that may result from any investment. A summary version of the Policy may be made available by The Bloom Group on its website, from time to time, and a copy of the full version of the Policy is available upon request. In the event of any conflict or inconsistency between the summary version of the Policy and the full version of the Policy, the terms of the full version of the Policy shall prevail.
Out-of-Pocket Expenses

In addition to the compensation The Bloom Group will receive for providing the Services, I agree that The Bloom Group will be entitled to be reimbursed by me for all the reasonable out-of-pocket expenses that may be incurred by The Bloom Group in the provision of its Services to me (the “Expenses”), including, without limitation, courier expenses and long-distance telephone call charges.

Payment of Fees and Expenses

I agree that the Fees and Expenses are payable from the date of this Contract and will be payable to The Bloom Group monthly or at such other frequencies as The Bloom Group, in its sole discretion, considers reasonable. Unless otherwise agreed to between myself and The Bloom Group, all of The Bloom Group’s Fees and Expenses shall be charged to and paid out of the my Trust Fund. If my Trust Fund is insufficient to pay the Fees and Expenses, I agree that I will be responsible for promptly paying to The Bloom Group any shortfall in the Fees and/or Expenses. Upon request, The Bloom Group will provide me with a printed record of my Trust Fund including a record of any payment of Fees and/or Expenses to The Bloom Group or any distributions to myself.

Personal Information & Authorization

I hereby authorize and agree:

1. to the release of my personal information to The Bloom Group to allow The Bloom Group to provide the Services to me (my Social Insurance Number is ________________);

2. to give The Bloom Group signing authority with my Pension Income providers;

3. to have any Pension Income cheques payable to me prepared in the name of myself, __________________ [print name] c/o The Bloom Group Community Services Society (TBGCSS) Adult Guardianship Program (AGP); and

4. to have my Pension Income cheques sent to The Bloom Group’s address at 315B Powell Street, Adult Guardian Program, Vancouver, BC V6A 1G5.

I agree to sign any authorization forms or other documents or take any actions that may be required to provide The Bloom Group with the above authorizations and to allow The Bloom Group to provide the Services to me.
Termination of Contract

This Contract may be terminated by either me or The Bloom Group by written notice to the other party, such termination to be effective upon the receipt of the written notice of termination by the other party.

Dated this _____ day of __________________________, 20___

Witness Signature
Print name:

Client Signature

Address

Occupation

Phone Number:

The Bloom Group Community Services Society by its authorized signatory:

Print Name:
PENSION MANAGEMENT CONTRACT

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Dated this _____ day of ______________________, 20____

Witness Signature
Print name:

Client Signature

Address

Occupation

Phone Number:

The Bloom Group Community Services Society by its authorized signatory:

Print Name:
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PAYMENT OF FEES AND EXPENSES

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Termination of Contract

This Contract may be terminated by either me or The Bloom Group by written notice to the other party, such termination to be effective upon the receipt of the written notice of termination by the other party.

Dated this _____ day of ________________________, 20___

Witness Signature
Print name: ____________________________________________
Address ________________________________________________
Occupation _____________________________________________
Phone Number: _____________________________

Client Signature

The Bloom Group Community Services Society by its authorized signatory:

Print Name: ____________________________________________
Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Service Canada regarding your Canada Pension Plan (CPP) and Old Age Security (OAS) benefits. It allows Service Canada to communicate to this authorized person your personal information concerning CPP/OAS benefits, payments, income, contributions and changes to your address (excluding the address where your cheque is mailed or the bank account where the payment is deposited). It does not provide authority for the person to apply for benefits for you, change your payment address or request/change voluntary tax withheld. If our records indicate that a legal representative, such as a Power of Attorney or Trustee, is authorized to act on your behalf, all communications will be made through that legal representative.

Note: Third Parties are not currently authorized to use the CPP/OAS On-line Services.

Section 1: Your Consent (you must complete and sign this section)

First Name ___________________________ Initial ___________________________ Family Name ___________________________ Social Insurance Number ___________________________

I hereby give my consent for Service Canada to communicate personal information on my behalf and to act on information received from the authorized person, named in Section 2, concerning CPP/OAS benefits, payments, income, contributions and changes to my address (excluding the address where my cheque is mailed or the bank account where the payment is deposited) on the programs below:

Check applicable box(es): 
☐ Canada Pension Plan  ☐ Old Age Security

This consent form does not provide authority to the person to apply for benefits on my behalf or to change my payment address (the address where my cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withheld. I understand that this consent remains valid unless I cancel it in writing and that it is only valid if Service Canada receives this form within one year from the date I sign it. I also understand that this consent is revoked in the event of my death.

Your Signature: X ___________________________ Date: ________/_______/_______

Section 2: The person you would like us to communicate with must complete and sign this section

Relationship to client: Pension Trustee

The Bloom Group Community Service Society – Adult Guardianship Program

Name ___________________________

Telephone numbers: ___________________________ Fax: 604-606-0321

Complete mailing address: 315B Powell Street (No., Street, Apt., P.O. Box, R.R.) Vancouver BC Canada V6A 1G5

City Province Country Postal Code

I understand that I can communicate with Service Canada on the program(s) checked off above to give and receive personal information on behalf of the person named in Section 1. I also understand that I do not have the authority to apply for a benefit or to change the payment address (the address where the cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withheld on this person's behalf.

Signature: X ___________________________ Date: ________/_______/_______

Protection of your personal information

CPP and OAS cannot give your personal information to any person or organization without your written consent, except where authorized by CPP or OAS legislation. You (or your authorized legal representative) have the right to request a copy of the information in your file.

How to reach CPP and OAS: 

In Canada and the United States, call
   - English: 1-800-277-9914
   - French: 1-800-277-9915
   - TTY users: 1-800-255-4786

To learn more about this form, Canada Pension Plan, Old Age Security Program and Service Canada on-line services, please visit our Internet site at: servicecanada.gc.ca

Service Canada delivers Human Resources and Skills Development Canada programs and services for the Government of Canada.

Disponible en français
Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Service Canada regarding your Canada Pension Plan (CPP) and Old Age Security (OAS) benefits. It allows Service Canada to communicate to this authorized person your personal information concerning CPP/OAS benefits, payments, income, contributions and changes to your address (excluding the address where your cheque is mailed or the bank account where the payment is deposited). It does not provide authority for the person to apply for benefits on your behalf, or change your payment address or request/change voluntary tax withholding. If our records indicate that a legal representative, such as a Power of Attorney or Trustee, is authorized to act on your behalf, all communications will be made through that legal representative.

Note: Third Parties are not currently authorized to use the CPP/OAS On-line Services.

Section 1 : Your Consent (you must complete and sign this section)

First Name __________________________ Initial __________________________ Family Name __________________________ Social Insurance Number __________________________

I hereby give my consent for Service Canada to communicate personal information on my behalf and to act on information received from the authorized person, named in Section 2, concerning CPP/OAS benefits, payments, income, contributions and changes to my address (excluding the address where my cheque is mailed or the bank account where the payment is deposited) on the programs below:

Check applicable box(es): □ Canada Pension Plan □ Old Age Security

This consent form does not provide authority to the person to apply for benefits on my behalf or to change my payment address (the address where my cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withholding. I understand that this consent remains valid unless I cancel it in writing and that it is only valid if Service Canada receives this form within one year from the date I sign it. I also understand that this consent is revoked in the event of my death.

Your Signature: X __________________________ Date: ____________ Year Month Day

Section 2 : The person you would like us to communicate with must complete and sign this section

Relationship to client: Pension Trustee

The Bloom Group Community Service Society – Adult Guardianship Program

Name __________________________

Telephone numbers: __________________________ Fax: 604-606-0321

Complete mailing address: 315B Powell Street Vancouver BC CANADA V6A 1G5

(No., Street, Apt., P.O. Box, R.R.) City ______ Province ______ Country ______ Postal Code ______

I understand that I can communicate with Service Canada on the program(s) checked above to give and receive personal information on behalf of the person named in Section 1. I also understand that I do not have the authority to apply for a benefit or to change the payment address (the address where the cheque is mailed or the bank account where the payment is deposited) or request/change voluntary tax withholding on this person's behalf.

Signature: X __________________________ Date: ____________ Year Month Day

Protection of your personal information

CPP and OAS cannot give your personal information to any person or organization without your written consent, except where authorized by CPP or OAS legislation. You (or your authorized legal representative) have the right to request a copy of the information in your file.

How to reach CPP and OAS: In Canada and the United States, call

- English: 1-800-277-9814
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To learn more about this form, Canada Pension Plan, Old Age Security Program and Service Canada on-line services, please visit our Internet site at: servicecanada.gc.ca

Service Canada delivers Human Resources and Skills Development Canada programs and services for the Government of Canada.

Disponible en français
Authorizing or Cancelling a Representative

Important – If you moved recently, update your address and contact information with the Canada Revenue Agency (CRA) online if you are registered with MyAccount at www.cra-arc.gc.ca/myaccount, by telephone at 1-800-959-8281, or in writing.

Complete this form to authorize the CRA to deal with another person who would act as your representative for income tax matters or to cancel any existing representatives on your account. Only forms received with a valid account number will be processed.

By registering with MyAccount at www.cra-arc.gc.ca/myaccount, you will be able to provide immediate access to your representative and cancel and manage your representatives through "Authorize my representative." You can also authorize or cancel a representative by completing this form and mailing it to your tax centre. We aim to process this paper form in 20 business days or less from the date it is received at the tax centre. To immediately cancel a representative, call us at 1-800-959-8281.

Part 1 – Taxpayer information

You will need to complete a separate Form T1013 for each account and representative. Complete the line that applies:

SIN, TTN or ITN

First name: __________________________ Last name: __________________________

Trust account number

Trust name: __________________________

T5 filer identification number

Filer name: __________________________

Part 2 – Representative information and authorization

Name of your representative (individual or business): ____________________________

Mailing address: ____________________________

Do not complete a new form every year if there are no changes. Complete section A or B, as applicable.

A. Authorize online access (includes access by telephone, in person, and in writing)

To grant online access to your representative, your representative must register online through "Represent a Client" at www.cra-arc.gc.ca/representatives and obtain a RepID or GroupID or register their business number (BN). Our online services do not have a year-specific option. Therefore, your representative will have access to all tax years.

By completing this section to authorize a representative for a trust account, the representative will have access to all tax years with no online access.

ReplID

First name: __________________________ Last name: __________________________

GroupID

Name of group: __________________________

Business number (BN)

Name of business: __________________________

Enter the level of authorization (level 1 or 2): [ ] If you do not specify a level of authorization, we will assign a level 1.

If you authorize your representative for online access and have a "care of" address, you will receive a letter to confirm the authorization.

or

B. Authorize access by telephone, in person, and in writing (no online access)

Enter the full name of the individual or business you are authorizing. If you do not identify a specific representative from that business, you will be authorizing the CRA to deal with any representative from that business.

Individual: First name: __________________________ Last name: __________________________

Name of business: The Bloom Group Community Service Society - Adult Guardianship Program

Telephone: __________________________ Ext: __________________________ Fax: 604-606-0321

Tick the appropriate box and indicate the level of authorization:

[ ] All tax years (past, present, and future) Level of authorization (level 1 or 2) [2] If you do not specify a level of authorization, we will assign a level 1.

or

[ ] Enter the applicable tax year or years (past and/or present), and specify the level of authorization (level 1 or 2) for each tax year.

Tax year(s)

Level of authorization

[ ]

[ ]

T1013 (15) (Vous pouvez obtenir ce formulaire en français à www.arc.gc.ca/formulaires ou en composant le 1-800-959-7383.)
Part 3 – Authorization expiry date

Enter an expiry date, if applicable, otherwise the authorization will stay in effect until you or your representative cancels it or we are notified of your death.

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Day</th>
</tr>
</thead>
</table>

Part 4 – Cancel one or more existing authorizations

Complete this section only to cancel an existing authorization. Tick the appropriate box.

☑ Cancel all authorizations

or

☐ Cancel the authorizations given for the individual, group, or business identified below:

ReplID

GroupID

Business number (BN)

First name: ___________________ Last name: ___________________

Name of group: ___________________

Name of business: ___________________

Part 5 – Signature and date

If you are the taxpayer, you must sign and date this form. If you are the legal representative, you must tick the box below, and sign and date this form.

☐ I am the legal representative for this taxpayer or estate/trust (executor/administrator, power of attorney, the legal guardian or the trustee or custodian of this trust account).

Important: You must send a complete copy of the legal document giving you the authority to act in this capacity to the taxpayer’s tax centre. Read the attached information sheet for tax centre addresses.

If two or more legal representatives are acting jointly on the taxpayer’s behalf, each legal representative must sign below.

Signature of taxpayer or each legal representative, a parent if taxpayer is under the age of 16, a witness when signed with a mark

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Day</th>
</tr>
</thead>
</table>

Date of signature

If your representative has not electronically submitted this form on your behalf then it must be submitted within six months of the date of signature. If not, it will not be processed.
Date: ________________

Canada Customs and Revenue Agency  
Surrey Taxation Centre  
9755 King George Hwy  
Surrey, BC  
V3T 5E1

Dear Sir or Madam:

RE: ________________

SIN: ________________

If I have direct deposit to a bank account please discontinue and redirect cheques made payable to:

_____________________
(client name)

c/o The Bloom Group Community Services Society  
Attention: Adult Guardianship Program (AGP)  
315B Powell Street  
Vancouver, BC  V6A 1G5

Sincerely,

_____________________

Client Signature

(Direct contact for CCRA 1-800-959-8281)

CCRA Stop Direct Deposit 2013
RELEASE OF INFORMATION

To: 

I, ___________________________ do hereby give my permission to The Bloom Group Community Services Society, Adult Guardianship Workers (or representative) to discuss the account mentioned below with representatives of your company:

- BC Hydro: [ ] Account #: ___________________________
- Bell Canada: [ ] Account #: ___________________________
- Rogers: [ ] Account #: ___________________________
- Shaw: [ ] Account #: ___________________________
- Telus: [ ] Account #: ___________________________
- Terasen: [ ] Account #: ___________________________
- Other: [ ] Account #: ___________________________

FOR PRIVACY REASONS, PLEASE ONLY GIVE INFORMATION ON 1 BILL PER FORM.

Client Signature: ___________________________ Date: ___________________________
Address: ___________________________ Phone: ___________________________

Witness: Print Name: ___________________________ Signature: ___________________________
Address: ___________________________ Phone: ___________________________

Adult Guardianship Worker mainly managing account at Adult Guardianship Program:

Worker #: _________ Name: ___________________________ Phone: ___________________________
Date:

Service Provider:

To Whom It May Concern:

RE: Account Holder:

Account Number:

Address:

I, ______________, am writing to inform you that I have asked The Bloom Group Community Service Society Adult Guardianship Program to help me manage my finances. They are also assisting me with my day to day finances. I give my permission to The Bloom Group Community Services Society – AGP representatives to discuss the account mentioned with representatives from your company. In addition, I am requesting that my monthly bills be sent to The Bloom Group Adult Guardianship Program for payment.

Please change my mailing address and mail bills or statements and any correspondences to following address:

______________________
c/o The Bloom Group Community Services Society
Adult Guardianship Program
315B Powell Street
Vancouver, BC V6A 1G5

If you should have any questions please contact my adult guardianship worker ______________ at The Bloom Group Community Services Society Adult Guardianship Program at 604-606-

Sincerely,

______________________
Signature:
RELEASE OF INFORMATION

To: ______________________________

I, ______________________________ do hereby give my permission to The Bloom Group Community Services Society, Adult Guardianship Workers (or representative) to discuss the account mentioned below with representatives of your company:

BC Hydro: [ ] Account #: ______________________________
Bell Canada: [ ] Account #: ______________________________
Rogers: [ ] Account #: ______________________________
Shaw: [ ] Account #: ______________________________
Telus: [ ] Account #: ______________________________
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FOR PRIVACY REASONS, PLEASE ONLY GIVE INFORMATION ON 1 BILL PER FORM.

Client Signature: ______________________________ Date: ______________________________
Address: ______________________________ Phone: ______________________________
Witness: Print Name: ______________________________ Signature: ______________________________
Address: ______________________________ Phone: ______________________________

Adult Guardianship Worker mainly managing account at Adult Guardianship Program:
Worker #: ___________ Name: ______________________________ Phone: ______________________________
Date:

Service Provider:

To Whom It May Concern:

RE: Account Holder:

Account Number:

Address:

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Client Signature: ________________________________ Date: ________________________________

Address: ________________________________ Phone: ________________________________

Witness: Print Name: ________________________________ Signature: ________________________________

Address: ________________________________ Phone: ________________________________

Adult Guardianship Worker mainly managing account at Adult Guardianship Program:

Worker #: __________ Name: ________________________________ Phone: ________________________________
Date:

Service Provider:

To Whom It May Concern:

RE: Account Holder:

Account Number:

Address:

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315B Powell Street
Vancouver, BC V6A 1G5

If you should have any questions please contact my adult guardianship worker ____________________________ at The Bloom Group Community Services Society Adult Guardianship Program at 604-606-

Sincerely,

Signature: ________________
CONSENT TO DISCLOSURE OF INFORMATION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the Employment and Assistance Act and the Employment and Assistance for Persons with Disabilities Act. The collection, use and disclosure of personal information is subject to the provisions of the Freedom of Information and Protection of Privacy Act. You have the right to revoke this consent at any time. Any questions regarding this form should be directed to your local Employment and Assistance office.

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>BIRTH DATE</th>
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<tbody>
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</table>

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<tr>
<th>SR NUMBER (IF APPLICABLE)</th>
<th>CASE NUMBER (IF APPLICABLE)</th>
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</table>

I consent to the disclosure of any personal information currently held under the custody and control of the Ministry of Social Development and Social Innovation subject to the following limitations:

☐ 1. The following specific information only. (If more space is required, please attach an additional page)

☐ 2. All information relevant to the determination of eligibility for:
   - Income Assistance
   - Hardship Assistance
   - Bus Pass Program
   - Disability Assistance
   - Supplements

This information may be disclosed to an agency and/or an individual:

<table>
<thead>
<tr>
<th>AGENCY NAME</th>
<th>INDIVIDUAL NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bloom Group Community Service Society - Adult Guardianship Pgrm</td>
<td>Adult Guardianship Workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>315B Powell Street</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY / TOWN</th>
<th>POSTAL CODE</th>
<th>TELEPHONE NUMBER</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver, BC</td>
<td>V6A 1G5</td>
<td>604-606-0321</td>
<td></td>
</tr>
</tbody>
</table>

This consent is effective on the date it is signed and will remain valid until I request that it be cancelled.

SIGNATURE OF PERSON GIVING CONSENT

DATE (YYYY MMM DD)

NOTE: If you are signing on behalf of the Ministry Client, you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Consent.